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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Discogram with Post CT Scan

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon
Board Certified Spine Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Adverse Determination Letters, 2/18/10, 2/26/10
Orthopedics 10/31/08-2/8/10
Therapy & Diagnostics 12/7/09
XRay Lumbar 7/31/09
Imaging Center, 1/9/09
Memorial MRI 11/24/08, 9/25/09, 4/14/09
7/6/07
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY
This is a patient who was injured. The patient has undergone previous L4/L5 disc herniation. There is evidence of ongoing pressure on recent MRI scan affecting the L4 root, resulting in radiculopathy. The treating physician has recommended the patient undergo a discectomy and fusion at L4/L5. Lumbar discogram with post CT scan has been denied upon peer review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
While this patient has been cleared psychologically for surgery, this patient does not have documented instability noted on flexion/extension views. The patient has not had two

previous discectomies, which would also place him in a category for consideration of fusion and thereby warrant discography. In this particular instance, the neurological findings are consistent with the L4 radiculopathy, as is the MRI scan. In the absence of instability, a fusion would not be indicated per the ODG Guidelines. There is no indication for lumbar discogram with post CT scan. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds that medical necessity does not exist at this time for Lumbar Discogram with Post CT Scan.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)